Department of Mental Health (DMH)
Mental Health Services Act (MHSA)
Community Services and Supports Component
Stakeholder Input Process

Workgroup: Short-Term Strategies
March 16, 2005

Meeting Summary
For Discussion Only

I. Background

The Mental Health Services Act (MHSA) became state law on January 1, 2005. The passage of the Mental Health Services Act (MHSA) has created the expectation of a comprehensive planning process within the public mental health system. The multiple components of the Act are designed to support one another leading to a transformed culturally competent mental health system. While the comprehensive state and county planning processes are underway, the Department of Mental Health (DMH) is seeking ideas for short-term strategies that may be funded prior to completion of the full stakeholder process. It is expected that funding for these strategies will be from DMH's funding pool, 5% for implementation and oversight.

The workgroup session of the MHSA stakeholder input process on short-term strategies was held on March 16, 2005 in Sacramento. A Client and Family Member (CFM) Pre-Meeting, held from 9:30 – 11:30 a.m., provided an opportunity for clients and family members to discuss the workgroup session purpose, review the workgroup agenda, ask questions, provide feedback and network with each other. Both the pre-meeting and the workgroup session were introduced with the same basic information and overview. The workgroup was held from 1:00 – 4:00 p.m.

Prior to the March 1, 2005 conference call on short-term strategies, DMH posted three documents on its website describing their initial ideas for strategies: network of care, suicide prevention and telemedicine. These strategies were suggested by DMH as initial examples to which stakeholders could respond as part of the process of developing short-term strategies. In advance of the workgroup, the agenda for the session was also posted on the DMH website. DMH also proposed criteria by which to evaluate the strategies:

A. Consistent with vision of MHSA
B. Allowable with MHSA Funds
C. General consensus among stakeholders
D. Benefiting individuals in all or most counties – statewide impact on clients

E. Projects where one-time or short-term funding is needed; may require commitments to keep some programs running

Fifty-four (54) people attended the morning Client and Family Member (CFM) pre-meeting for both Short-Term Strategies and Small County Issues and 58 attended the afternoon workgroup session for Short-Term Strategies.

A. Anticipated Outcomes

The outcomes of the workgroup meeting are:

1. To develop criteria to evaluate which short-term strategies should be pursued.

2. To provide suggestions on programs and services that DMH should consider funding as short-term strategies.

II. Client and Family Member Pre-Meeting (9:30 – 11:30 am)

Fifty-four (54) people attended the morning Client and Family Member (CFM) pre-meeting for both Short-Term Strategies and Small County Issues. Simultaneous interpretation was available in American Sign Language (ASL).

Bobbie Wunsch, Pacific Health Consulting Group and facilitator of the MHSA stakeholder process, introduced the session by reminding people of upcoming dates for the MHSA stakeholder input, listed below. Ms. Wunsch introduced the two concurrent workgroup sessions, Short-Term Strategies and Small County Issues. The first part of the pre-meeting addressed common issues, including the review of the two agendas. Then participants divided into two smaller groups to ask questions and raise issues about the workgroup-specific agenda topics. By dividing into smaller groups, it was hoped that more individuals would be encouraged to add their voices to the discussion.

Ms. Wunsch thanked everyone who had provided feedback both at and following the last workgroup meeting concerning the role of pre-meetings in the MHSA stakeholder process and how they could best be organized. She explained that a short survey would be distributed at the end of the CFM pre-meeting to solicit client and family member feedback about the purpose and format of future pre-meetings. Future meetings may be facilitated in part by clients and family members who may also help to set the agendas. Some meetings may be conducted one way and others another way, depending on the topic.

A. Schedule of Meetings

The DMH website is improving and changing every day. In the top right hand corner of the website is a new MHSA “Save the Date” link to the schedule and location of upcoming meetings and conference calls.

Upcoming workgroup and conference call dates are:

- Friday, March 18, 3-4 pm: Financing Conference Call
- Wednesday, March 23: Second meeting on the CSS DRAFT Requirements, covering Sections V-IX (except Section VIII). The pre-meeting will begin at 9:30 a.m. and the workgroups at 1 p.m. Participants should go directly to the 1 p.m. small discussion groups based on age (children and youth, transition age youth, adults and older adults).
- Wednesday, March 30: Third meeting in the series on CSS, covering financing, including Section VIII of the CSS DRAFT Budget Requirements. The pre-meeting will begin at 9:30 a.m. and the workgroup at 1 p.m.
- Tuesday, April 5 and Wednesday, April 6: Second general stakeholder meetings. These meetings will cover the same material and have been divided into north and south locations to make each meeting more accessible; participants should plan to attend only one of these meetings. There will be one combined summary of both meetings, as though it were one meeting. The Los Angeles meeting will be held at the Burbank Hilton Hotel; while the Sacramento site has not been selected yet.

B. Review of Agenda

Babs Kavanaugh, facilitator from Pacific Health Consulting Group, gave an overview of the workgroup meeting agenda, intent and structure of the afternoon workgroup, and introduced the selection criteria for evaluating the short-term strategies.

Carol Hood, DMH Deputy Director, provided a brief overview of the draft selection criteria and introduced the discussion papers on the three suggested short-term strategy examples. Ms. Hood emphasized that DMH is looking for additional comments and input from stakeholders to add to and enhance this list. State staff and consultants were available to answer questions and provide clarification on the agenda topics.

The primary focus of the workgroup session covers two areas:

- Review addition of proposed criteria for evaluating short-term strategies and addition of criteria proposed by participants.
- Recommendations of additional short-term strategies and evaluation of them in light of the criteria. Then participants will be asked to identify their top three priorities. The rest of the discussion will be to add participant ideas for short-term strategies that would really transform the system and that meet the criteria. The outcome of the meeting will be a ranking of those short-term strategies that are most important to participants.

The afternoon workgroup will begin with the large group discussing and reaching consensus on the criteria for selection of the short-term strategies. This will be followed by small group discussions of ideas for short-term strategies and ranking to determine the top three ideas. Each of the tables will report their three highest-ranking ideas to the entire group.

Client and family member participants had the opportunity to discuss the workgroup session purpose and anticipated outcomes, review the workgroup agenda, ask questions and provide feedback about the criteria and short-term strategies suggested by DMH.

C. Client and Family Member Feedback and Questions

1. Questions and Comments about Communication with State and Process

Communication with the State

CFM Question: Will we get a copy of all the suggestions?
DMH Response: A description of the three short-term strategy ideas DMH has suggested can be found on the MHSA website as well as at the registration desk. In the workgroup session, all participants will be able to suggest other ideas. The summary of today's workgroup, posted next week, will contain all ideas suggested. This workgroup is stakeholder advisory to the department.

CFM Comment: This process seems to indicate that there will be no client choice or input. Our ideas are on a long list, get lost in the details and then become subject to what someone at DMH decides is acceptable. We are not hearing that our changes or input are getting any follow through. How can we get real ideas from real people taken to the top?
DMH Response: DMH is capturing all of the comments and information that have been gathered at the stakeholder meetings, during the conference calls and through email. The final date for the input on the Community Services and Support (CSS) DRAFT Requirements is April 1. The revision of that document will be available on May 1.

CFM Comment: We have no trust built up. If there is no immediate response to our ideas, it diminishes our sense of having a voice in the process. There is a general fear that ideas are not honored. Ideas that are already on the table (by DMH) will end up being those with the most strength. How do emails sent to DMH get captured?
DMH Response: The MHSA team is collecting the emails, but we have not been posting them. There is not a process regarding what is posted and what is not. We would need to check with the webmaster for the logistics of how to do this. The MHSA Team will make a note to clarify this and get back to the stakeholders.

CFM Comment: DMH should not select which emails to post. If this is a dialogue, everything should be posted. The consensus was that enrollment is a bad idea and yet it does not appear that DMH is deleting enrollment from the CSS DRAFT Requirements. Enrollment is not in the spirit of the law.

CFM Comment: Create a discussion or posting board on the website that everyone can submit to and read.

CFM Comment: How is all that we do here influencing what will be done? Is all this recording going into a book, put away on a shelf and that is it?
DMH Response: We are listening for ideas that DMH might pursue. In terms of MHSA, we have put forth many ideas – some supported, some not – to help us determine which are good ideas. We are reading and thinking and talking to the people who do the final writing. Is it influencing us? Absolutely. You are not seeing all the work at this point, but this is a time of thinking, discussing, and making recommendations. It is not a static process. Ideas can go into the whole process.

Meeting Process and Supplies

CFM Question: Can we have coffee and rolls at these meetings?
DMH Response: State funds cannot be used to provide food. There is no prohibition for bringing in your own foods.

CFM Comment: These meetings include a process of getting to know everybody. It is hard for people like me on medication, when I do not have food or snacks available.

CFM Question: Can the department research to see if providing coffee and food is a reasonable accommodation under the ADA?
DMH Response: Yes.

CFM Comment: I am surprised that childcare is not offered at these meetings.

CFM Question: Can DMH contract out to provide food and childcare for these meetings?
DMH Response: I will check on this and report back.

Meeting Summaries

CFM Comment: In reviewing the recent summary of the March 7 workgroup meeting, I noticed omissions of my comments.
DMH Response: DMH does not prepare the summary of the MHSA meetings. Pacific Health Consulting is preparing the summaries for each of the meetings as well as facilitating the meetings. DMH reviews the notes for clarity and accuracy of information. It is certainly a terrific challenge to capture all of the discussion.

CFM Comment: Regarding the summary posted for March 7 workgroup meeting, the larger methodology of the stakeholder process was not adhered to. The summary only focused on the first five sections of the CSS DRAFT Requirements. The basic concept of transformation of the system of change was not captured in the summary.
PHCG Response: The summaries are intended to represent the discussion at each of the meetings, but they are not a transcription. If any stakeholder feels that an idea is not represented, please email the department with that feedback and what specifically was not recorded. The summary will be revised.

Other Comments

CFM Comment: It is best as clients and family members to start small. We have to start on a small basis and formulate at the county level what we want. It is going to take a lot of communication and outreach. The discussion needs to be open and honest.

CFM Comment: Most consumers are not well versed in the details. I offer this quote: "*Simplify simplify."*

CFM Question: Nothing I am hearing has to do with youth. Youth are not going to read 37 pages of anything (i.e., the posted March 7 workgroup meeting summary). What can we do to be more involved than what is being offered here today?
DMH Response: We need more good ideas on how to involve more youth in the process. Please give us any ideas you have.

CFM Comment: I help myself by helping others help themselves.

CFM Comment: It is the spirit of us all that is being asked of us here. If we can take home the spirit, which is looking at recovery in the spirit of love. We are all here together in a spiritual sense, talking and looking at what we can do to help. I do not think that happens very often.

2. Questions and Comments about Funding

CFM Question: There was specific money allocated for each county for the plan-to-plan. Is that funding for planning? Will there be additional money available for implementation?
DMH Response: Yes, this funding is for the planning, and additional money will be provided for the implementation.

CFM Question: Can we choose to have many short-term strategies? Or does DMH plan to give all funds to one idea for the whole state?
DMH Response: The short-term strategies are ideas that may be funded prior to completion of the full stakeholder process. The funding for this comes from a portion of the initial state's funding of 5% for implementation and oversight. That amount is more than DMH needs for in-house administration. The funding guidelines are broad and allow some flexibility so we can use a portion to start some of the work.

CFM Question: Will the decision be made on the funding for the short-term strategies on April 1?
DMH Response: For Community Services and Support, the date for final stakeholder input is April 1. The discussion on short-term strategies will be ongoing.

CFM Question: Is DMH considering funding in the 2004-05 fiscal year?
DMH Response: There is a chance that some funding can be available in FY2004-05. DMH will have to get the authority from the Department of Finance and the Governor. Most things will be for next fiscal year 2005-2006.

CFM Question: Could a county be paid retroactively? For example, for a project started in April 2005, even though DMH makes its decision after June?
DMH Response: We have to take a good look at that. DMH will not pay for services for Community Services and Support prior to this coming fiscal year, even if it is approved.

CFM Question: Can you use unused monies next year that were designated for this year?
DMH Response: Approval for state funding under this category is for one-time or short-term strategies.

CFM Comment: We are concerned to take a risk on something that may not be funded in the current fiscal year.
DMH Response: Yes, that is pretty risky. There is some money available at the state level due to our budget process. MHSA dollars became available around the beginning of February 2005. I think the funding will come together more quickly than what you are used to.

CFM Question: What are the dollars attached to Network of Care? Large counties are doing this now and they say it can be easily done in any location. How much will DMH spend and how much will counties have to spend?
DMH Response: DMH's cost to go statewide is about $1.4 million. There is also a monthly maintenance fee that is population-based. An example is Los Angeles at about a $3,500 monthly and a small county would be about $300 monthly.

CFM Comment: Can the money for short-term strategies be given to each county to spend however they want? How is it allocated? For instance, can the Network of Care be put on each county's website? Why the $1.4 million cost to implement this statewide?
DMH Response: The amount of money, 5% of an estimated $250 million is $12.7 million, which has been reserved for state functions. After DMH functions, DMH has a few million left. Next year there will be 5% of an estimated $683 million ($34million) for all state needs.

DMH Response: We are not dictating to each county what they fund. One selection criterion is “anything allowable with MHSA funds.” DMH wants to have the biggest impact with limited funds to all counties.

3. Questions and Comments about Short-Term Strategy Workgroup

CFM Question. Where are the criteria for these short-term strategies?
DMH Response: The initial criteria were those listed on the PowerPoint presentation for the Short-Term Strategies conference call. These will be circulated during the workgroup session.

DMH Response: This discussion about short-term strategies is not a one-time only opportunity. This opportunity will be with us for a long time. How can this conversation continue after today? DMH wants to make decisions to initiate the strategies but knows that the discussion will continue and adjustments will be made over time.

CFM Comment: The structure of the table talk discussion as described on the agenda is a problem because any strategies discussed at a single table will not be heard by everyone and taken into account for the ranking of ideas. Consensus is likely to fall to DMH's three ideas.

Facilitator Response (PHCG): The table talk discussions are intended for each table or small group to have a more in-depth discussion of their recommendations, also taking into consideration those recommended by DMH. Time is set aside at the end of the meeting for each table to share their top three ideas with everyone. In this way, everyone will have the benefit of hearing the main ideas from each of the tables.

DMH Response: DMH is looking for a wide range and breadth of ideas.

CFM Question: How will ranking happen if everyone has different ideas? If we do not have consensus, how can we end up with only three ideas?
PHCG Response: Each table will have the opportunity to share common interests and learn about new ideas. This discussion should allow for a more in-depth review of ideas. The ranking, using the selection criteria, will provide DMH in guidance.

CFM Question: Are the three proposed ideas a done deal? Will DMH move forward regardless of our input?
DMH Response: No, DMH is looking to broaden the discussion and gather input on these ideas and others. These are ideas DMH received and have looked into. The Department wants more ideas before we move forward.

CFM Question: Regarding the three short-term strategy ideas, I have a concern about telemedicine, for example, so then do we just accept the other two?
DMH Response: The ideas presented are intended to begin the discussion. Today's conversation is to broaden the discussion and gather recommendations for other short-term strategies that will meet the selection criteria.

CFM Question: When the short-term strategies are defined, will each county have to determine whether they will want to be a part of the strategy?

DMH Response: Yes, it will be a county decision. The process today is to begin the discussion about the short-term strategies and to get things moving at the state level.

CFM Question: Let us say you jumpstart the three short-term strategies. What if one county does not want to participate in any of them?
DMH Response: DMH will not force a county to accept funding for work it does not or cannot perform.

CFM Comment: You put up draft criteria without discussing them.
PHCG Response: The workgroup, this afternoon will discuss and reach consensus on the selection criteria. This discussion is to generate ideas and to broaden the discussion.

4. Questions and Comments about Specific Short-Term Strategies

CFM Comment: Telemedicine/tele-psychiatry works well with children, as they are used to television and deal well with it.

CFM Question: Network of Care leaves out the many people who are not on the web. Will there be round-the-clock people and/or and 800 number to get referrals for those not on the web?
DMH Response: This is not a feature of the Network of Care website. The website puts all referral information in a prominent place. Regardless of what is on the web, you still need to call someone about a service. Half of the website visitors are providers, advocates, etc. As we move into rural areas where services are shared, some counties may not have the ability to use Network of Care. Not all those we are trying to serve are connected to the web.

CFM Comment: As a county served by Network of Care, we have a non-profit that decided to operate an 800 number for people who cannot access the website.

DMH Response: A volunteer can have a standardized interview process for the phone call that can be mailed to the caller.

CFM Comment: Regarding Network of Care, the first rule of the Internet is that the most valuable things on the Internet are free. Most sites are put up by people interested in a product. DMH can only put up state-sanctioned information. To be meaningful, you need to be able to offer opinions other than what DMH likes. It is a waste of money for DMH to put up a Network of Care. It will generate itself without DMH's funding.

CFM Comment: One great thing about San Diego County’s Network of Care is that clients and family members have access online to state representatives to present their views.

CFM Comment: The best place to start with short-term strategies is with education, e.g. peer-training programs, that include transportation. Clients and family members are at the root of system transformation. There are some great organizations that have already developed educational programs that could be utilized.

CFM Comment: Use state money to fund regional conferences on client ethics in the workplace, designed by clients. There could be another conference for designing a body that will monitor client ethics into the future. Many people do not want to belong to any organization. The idea of enrollment destroys reaching the unserved. We are told about a level playing field and it is not there. My county is not willing to pay to send clients and minorities to planning meetings. Instead, they send county people. How can voices be heard if counties exclude us? We need to be jump-started, but we have no cars, food, or hotel room provided.

CFM Comment: DMH should fund meals, transportation, etc. and try to gather people from every county in the state. Give us an opportunity to play on that level playing field DMH keeps talking about. This has the advantage of benefiting individuals versus the counties. Funding for clients and family members to participate is a short-term strategy that needs to be done now.

CFM Comment: This has been very productive. Unlike some stakeholders, I am here because I get paid to be here. I get paid for my time to read the documents and to make the binders for my organization. We need short-term strategies for skill-building that supports and fosters participation, e.g. mentorship, mentorship models, etc. I represent an organization whose members are providers, consumers and family members. Doing things more collaboratively should be a focus for short-term strategies.

CFM Comment: The very most important training that every county must do is to stamp out stigma. Get this out to everyone else. Here you are preaching to the choir. Get it out to the counties.

CFM Comment: At the top of everything is collaboration. Education falls under this. Why can't we come up collectively with a short-term education program for everyone?

CFM Comment: There is nothing more important than mental illness screening in our schools. There are so many suicides in schools. Children are overlooked. They cannot vote. They are lost in our system.

CFM Comment: Jumpstart the idea of training and schedule massive trainings all over the state. Currently there is no coordination of training and no standard requirements. The curriculum varies from region to region. Is it a budget problem? Training needs to happen now. System transformation is not possible without it.

CFM Comment: Use a portion of the dollars coming to groups to build the infrastructure for each of the groups. Have local and statewide conferences to provide training and ideas. Have clients and family members from National Alliance for the Mentally Ill

(NAMI), United Advocates of Children of California (UACC), and the California Network of Mental Health Clients (CNMHC) to collaborate to create this.

CFM Comment: Education and training are the most important short-term strategies. For future dollars, the federal government says every state should have mental health courts. We would like to see DMH help counties establish mental health courts. It is too expensive for counties to do themselves.

CFM Question: Is it possible to make it mandatory to have a youth crisis line (suicide and mental health)?

III. Workgroup on Short-term Strategies (1:00 – 4:00 p.m.)

58 stakeholders participated in the workgroup session on Short-Term Strategies on March 16, 2005, from 1:00 – 4:00 p.m. Carol Hood, DMH Deputy Director, thanked everyone for coming.

A. Purpose of Meeting and Organizational Structure of Workgroup Process

Babs Kavanaugh, facilitator from Pacific Health Consulting Group, explained the purpose of today's meetings and the organizational structure of the two concurrent workgroups, one to solicit input about challenges to small counties and the other on short-term strategies.

Ms. Kavanaugh gave an overview of the workgroup meeting agenda, intent and structure of the afternoon workgroup, and introduced the draft selection criteria for evaluating the short-term strategies (presented on a handout and displayed on a large chart).

Carol Hood, DMH Deputy Director, described the opportunity for the short-term strategies, the draft selection criteria and how the selection criteria would be used, and provided a brief overview of the three short-term strategy examples: network of care, telemedicine and suicide prevention.

Some short-term strategies may be funded prior to completion of the full stakeholder process. The funding for short-term strategies comes from a portion of the initial state's funding of 5% for DMH's implementation and oversight. The funding guidelines are broad and allow some flexibility for DMH to use a portion of the money to begin capacity building at the county level. DMH is interested in investing some of the extra monies from the 5% overall for our oversight costs. DMH wants to initiate statewide short-term programs with this money, while the planning continues at the local level.

DMH's hope for today's outcome is to get more clarity. These criteria were drafted to initiate the discussion. Please offer suggestions on making changes. As for the short-

term strategy suggestions, DMH wants to hear your ideas of short-term strategies for DMH to pursue.

B. The Selection Criteria

First, the participants reviewed and discussed each of the draft selection criteria. Next, the participants discussed suggested changes and additions. Then, the participants discussed which recommended additions and changes had consensus of the majority of the group. Below, the criteria, the discussion and any resulting changes are listed. The agreement of changes may be found at the conclusion of this section.

1. Criterion A – Consistent with Vision of MHSA

Discussion:

- What is the MHSA vision? Need clarification.
  - **DMH Response:** DMH has a very clear vision statement:
    As a designated partner in this critical and historic undertaking, the California Department of Mental Health (DMH) will dedicate its resources and energies to work with stakeholders to create a state-of-the-art, culturally competent system that promotes recovery/wellness for adults and older adults with severe mental illness and resiliency for children with serious emotional disorders and their families. In its implementation responsibilities under the MHSA, DMH pledges to look beyond "business as usual" to help build a system where access will be easier, services are more effective, out-of-home and institutional care are reduced and stigma toward those with severe mental illness or serious emotional disturbance no longer exists.

Level of Agreement:

There was general consensus that Criterion A was accepted as a selection criteria.

2. Criterion B – Allowable with MHSA Funds

- ***Discussion:*** Focus on keeping these funds from being supplanted. County Mental Health has the authority to provide for mental health services. If funding is used before the plan is approved, it can be supplanted. It seems there is no way out of that, unless it is clearly not to be used by county Medi-Cal.
- Consider adding, "Funding for short-term strategies would be for programs that do not have other available funding. The funding would not supplant other funding."

Level of Agreement:

- Participants supporting these different additions were about equal, by a show of hands. No consensus was reached to make this addition.

- An example of supplantation is telemedicine, which can be funded by Medi-Cal. As a point of clarification, Medi-Cal does not fund the start-up costs, such as acquisition of a large television or installation of T1 line, etc. Once online and in service, medication management time can be billed to Medi-Cal.
- Medi-Cal does not cover a person who is in jail, so supplantation would not be a concern for those people.
  - **DMH Response:** Typically funding sources do not allow one-time funding; but here DMH can offer one-time needs. For example, a program purchase of a van for transportation.
- What about using the money for dental care? Mental health patients need good teeth, too.
  - **DMH Response:** There are other programs that can cover dental services. We need to be careful not to give the money away too broadly.

3. Criterion C – General Consensus among Stakeholders

Discussion:

- Use an inclusive and transparent process; i.e., one that demonstrates that the process is inclusive and that no one can say secret decisions are being made.
- What is meant by “transparent”?
  - **Answer from Participant:** "Transparent" means it is clear how we arrived at the idea.

Level of Agreement:

- There was general consensus to add “using an inclusive and transparent process” to the criterion.

4. Criterion D. Benefiting Individuals in All or Most Counties – Statewide Impact on Clients

Discussion:

Note: There was brief discussion and general consensus that this criterion is important. Several aspects of it were discussed in more detail and these are listed separately below.

- The language should include *families*, for instance “statewide impact on clients and families.”
- “Clients” does not include those who are not yet clients.
- Change the word “clients” to other choices, including: individuals, clients/consumers, participants or citizens.

Level of Agreement:

- The suggested language changes, by a show of hands, were fairly equal in preference; therefore no consensus was reached. It was suggested that there be some further discussion about which of those terms listed about most represent who would benefit.

Discussion:

- In Criterion D, add “promoting prevention and/or early intervention.” Services should have features that include prevention and early intervention.
- Adding “prevention and early intervention” may be too directive about where the money is going and may exclude other choices. Do not recommend a criterion that is unduly limiting. Be careful it is not worded so money cannot be used for deserving programs that are not prevention/early intervention.
- The Services emphasis in the CSS DRAFT Requirements goes to those who have severe needs. It is missing people who could be reached at earlier point. Let's encourage the promotion of prevention when the opportunity is here.
- Telemedicine is a great example of a strategy that has prevention and early intervention characteristics. Emphasis should be placed on affirmative things and not be too restrictive.

Level of Agreement:

- Including prevention drew general agreement from the group. The one caution was that limiting it to prevention and early intervention would be too restrictive.

Additional comments:

- In Criterion D, add, “helps address unmet needs.”
- Re: "statewide impact": Put short-term dollars where the needs are today. The strongest impact will come from improving existing community services such as institutions, in-home care, etc. Let us make the most out of each dollar.
- Medi-Cal should be available to all who need it: clients, consumers, family members and those who are mentally ill.

5. Criterion E. Projects Where One-Time or Short-Term Funding is Needed; May Require Commitments to Keep Some Programs Running

Discussion:

- One-time short-term funding is not good.
  - **DMH Response:** Sometimes you need one-time funding, for example, computer equipment for a certain program. Sometimes it takes one-time funding to make ongoing services available.
- Please clarify “short-term.”
  - **DMH Response:** Generally short-term is one year, though that can possibly stretch to two years. The longer the time required for the funding, the more the administration will be concerned about where the dollars are going. It is best to spend it on needed programs sooner rather than later.

- Consider adding a criterion about ensuring a tangible result so that the accomplishments can be demonstrated in a given time period.
- Add “results oriented”, i.e. results are visible to all Californians.

Level of Agreement:
- Consensus to add “results are visible to all Californians” to the criterion.

6. Agreement on Revisions to Draft Criteria

Additions and changes reflecting consensus of the group are in italics below.

Revised Draft Criteria for Evaluating Short-Term Strategies

A. Consistent with vision of MHSA.
B. Allowable with MHSA Funds.
C. General consensus among stakeholders *using an inclusive and transparent process.*
D. Benefiting individuals in all or most counties – statewide impact on clients.
E. Projects where one-time or short-term funding is needed; may require commitments to keep some programs running.
F. *Results are visible to all Californians.*

C. Discussion of Short-Term Strategies

1. Introduction to Short-Term Strategies

Carol Hood gave a brief introduction to the three strategy examples that were described in the discussion papers and are listed on the Participant Discussion Feedback Form for the table talk discussions.

> 1. Network of Care: a website concept that is currently working in four or five counties. The site offers a comprehensive community resource directory, a library of documents and articles and other useful links. The Network of Care is used by consumers and family members, providers, advocates, and anyone interested in the information provided.
>
> 2. Suicide Prevention: currently there are state and national resources for expanding suicide prevention. DMH is asking whether there is general consensus to do something on suicide prevention in the short-term? If so, what might that be?
>
> 3. Telemedicine: involves a use of technology to provide access in areas where specialty services are not available, especially in remote geographic areas. For example, how do you access a child psychiatrist if none exists locally? This is an important issue for small counties. It costs about $12-15,000 per site to set up telemedicine services. Equipment includes a television set and a T1 line, plus

ongoing service costs. Ongoing services may be eligible for Medi-Cal, but the equipment must be funded with other sources.

2. Questions and Comments about Short-Term Strategies

- Sometimes we are the only provider in remote locations. What kinds of criteria are there for funding? Who gets these funds?
  - **DMH Response:** DMH will need to explore some questions in regard to each recommended short-term strategy. First, is it doable, and second, can DMH get it through the state budget process?

- DMH gave cost estimates on two options, but none on suicide prevention.
  - **DMH Response:** It depends on what you do. Cost is unknown, depending on the strategy.
- Will DMH put out a specific time frame for short-term strategies ideas? Is there a forum outside this room to give input?
  - **DMH Response:** Yes, this is not a one-time only opportunity. DMH wants to be flexible so some of these can be considered and implemented early. The Department wants to have the door open to implement priorities now or next year. We are watching for opportunities.

3. Large Group Discussion of Short-Term Strategies

- Regarding the process at each table, do we have to rank only the three state proposals? Can we have the large group give ideas, and then discuss these in the small groups?
- Will we spend the whole time discussing DMH's options or will we have time to input some other ideas?
  - **Facilitator (PHCG) Response:** You will have at least one hour to discuss and list any strategies you want to suggest. You are not expected to only rank DMH examples. You can rank all of the strategies that you list in your group as well as those suggested by DMH.

Participants reached consensus on using some time to brainstorm possible short-term strategies as a large group before going into the small groups.

Short-Term Strategies Brainstorming List

Education and Training
Collaboration

- Educate children, clients, and family. Fund educational programs offered by client/consumer/advocacy groups, e.g. NAMI, UACC, and CNMHC. Collaborate with the three groups to create the educational programs.

- Can someone elaborate on the strategy to fund the trainings provided by the three organizations?
  - **Answer:** NAMI, UACC, and CNMHC teach a Mental Health 101, e.g. how to work in the workplace and how to access services. Without additional funding, these organizations do not have resources to go out into community to get those people who should be here. These organizations could also provide training to providers, if there was more available funding.
- Fund development strategies linked to sustainability, e.g., several organizations doing training together for Network of Care. It is important to articulate how these programs and services build on sustainability.
- Fund coalition building and provide model training throughout the state. Offer short-term loans for start-up costs for programs. Provide stipends for consumers, not students.
- Develop strategies that address outreach, education and team building, three components to be used together. Short-term strategies are needed for policy issues, stigma and provider education.

Provider/Referrer Training

- Two premier educational programs are Family-to-Family and Peer-to-Peer. These operate in our own voice and employ consumers. There is a provider program that teaches providers about what a consumer goes through from a first hand experience. Also Los Angeles County has criminal justice training. There are a lot of programs in effect with great success rates, but additional funding is needed.
- Promote readiness of providers. People need an attitude of readiness. Providers also need funding for substitutes at their work so they can get away from their job for training.
- Provide primary care support services, consultation and training. Depression drugs are the largest prescribed class of medications. There is need for an evaluation, consultation, and training for physicians to learn how to better treat those with multiple diagnoses and in the use of medications.

Employer Training

- Develop short-term strategies to promote county trainings that include MHSA content, as well as models of best practices for what works and include clients in the training. Provide training on client ethics that supports better understanding of how it feels to be in the client's place. Get the same information into the hands of bureaucrats – to learn what is recovery. We need transformative agents before the plans are completed.
- More is needed on ethics training for employers.

Other Training Ideas

- Cover start-up costs for Trauma Treatment Training.
- Start with Stamp Out Stigma programs. The first step is to get everyone educated about mental health and mental illness.

Outreach

- Involve clients and family members including people of color who are not currently involved in meaningful training such as partnerships and collaboration.
- Outreach to other groups with a focus on persons of color. As a NAMI member I see that we do need more training and education especially in Native American populations.
- When doing outreach for stakeholder input, we need to go outside state organizations to reach those who are not served. State and County employees who attend have expense accounts, wages, etc. The people who need to be stakeholders in this process do not have the resources.
- Provide additional funding to counties for enhanced trainings. It does not seem that all the people who are stakeholders are here.
- Provide funding for more provider education opportunities. Give more money to providers to be educated about this process and the opportunities for input. Without the instruction and training, when the system is implemented it will be the same-old, same-old.

Networking

- Clients need a level playing field. Provide more dollars for a series of state and regional meetings with the goal of maximizing the participation of clients/families. Set up a series of state and regional meetings with the goal of getting the maximum number of clients to come together to network. Clients and family members do not get the chance to get together without a high-powered structure in control of the meetings.
- Create two kinds of meetings: 1) Network and share information and concerns, and 2) Address "ethical" issues of consumer employment. Clients are more likely to be threatened, betrayed and abused in the work place and end up unemployable due to this bad treatment.
- Provide alternative meeting times and places for input for employed and busy individuals. These meetings are always held during the week and it is hard to come, even for providers. There must be a way for more to come to the meetings.

Dual Diagnosis/Co-Occurring Disorders

- Along with suicide, is DMH considering drug addiction? There is nothing about addiction to this paper on suicide prevention. In my experience, the two are very connected.
  - **DMH Response:** Co-occurring substance abuse as a component in suicide prevention/intervention can be added.
- Mental health screening includes screening on drug addiction.
- Consider co–occurring services (substance abuse programs). I am on medication and have been through many years of hard drugs. It would be great to help people get off drugs and on medication for those who need it.

Other

- Develop the infrastructure for respite programs; this can be a benefit to all consumers.

- Implement Children's System of Care.
- Fund peer-run self-help programs based on "Best Practices and Promising Practices."
- Enhance the MHSA website to include specific dates about meetings and events and information at a central location. A website is needed that is streamlined and has linkages to counties calendars and their events and scheduling.
- Decide how to spend what we have and what we will get.
- We are at a moment of opportunity. Counties are asked to present their internal training programs. Counties are disconnected. We need a vision of MHSA and a vision of the results.

D. Table Talk Discussion (Small Group Discussion)

There were thirteen small group table discussions. Each table listed their ideas for short-term strategies and then identified their top three choices. The chart below shows how many tables ranked each item listed as a top priority. Training was grouped together as a topic, with the specific types of training topics or targets listed individually.

Total Number of Tables	Suggested Short-Term Strategies
12	Training
	Client and family member outreach and training (4)
	General trainings (4)
	Evidence-Based Practice trainings (1)
	Training for participation in MHSA (1)
	Training for transformation (1)
	Provider trainings (1)
5	Suicide prevention
4	Telemedicine
3	Network of care
3	Co-occurring disorders services
2	Mental health courts
1	Networking
1	Partnerships with local universities
1	Youth programs
1	Wraparound services
1	"Warm Lines"
1	Respite care
1	Statewide marketing and media campaign
1	Investigate IT infrastructure needs

In addition to ranking their top three priorities, each table recorded other ideas for short-term strategies.

Training

- Provide training for providers on MHSA readiness.

- Facilitate readiness for implementation.
- Training on technologies.
- Provide training on evidence-based practices , including trauma training.
- Training for transformation: tools and technical assistance. Use the Client Network, NAMI and UACC as well as nontraditional outreach and inclusion: communities of color, educators, and other needed partners. Include a mentor piece that is meaningful and significant, with participation of consumers and family members, paying for their involvement and pairing them with mentors who are seasoned mental health advocates.
- Stamp Out Stigma.
- Team building.
- Trauma treatment.
- Dual diagnosis.
- Use the prepared trainings by CNMHC, NAMI and UACC.
- Training for employers to include anti-discrimination and unethical treatment of employees.
- Address ethical conflicts of clients working within the mental health system.
- Provide education and training funds.
- Provide training nights and week-ends and funds to pay for food, lodging and transportation.
- Train consumers as providers, using the University of Illinois, Chicago's Manual of Psychiatric Rehabilitation or other models.
- Train the trainers.
- Statewide coordination of education to family and clients is fundamental. Train client and family members.
- Provide state training for clients, one in the north and one in the south of the state, regional training and local grassroots trainings. Do not go through the three state organizations (NAMI, UACC and CNMHC), go through DMH.
- Mental health clients to train clients, family members, mental health providers and other stakeholders.
- Consultation to primary care physicians.
- Train Providers.
- Training for criminal justice and law enforcement.

Suicide Prevention and Trauma Treatment

- Utilize the statewide Suicide prevention plan and fund the start-up.
- Suicide prevention: will there be results in five years? Media and advertisement costs to promote issues are high.
- Provide drug addiction training in suicide prevention.
- Trauma treatment for suicide prevention.
- Garrett Lee Smith Memorial matching dollars, a recent bill passed concerning teen suicide.

Outreach and Collaboration

- Mental health outreach programs should emphasize cultural and linguistic competency.
- Provide statewide networking conferences for clients and family members and conferences for clients to establish an ethics policy.
- Fund coalition training between NAMI, UACC and CNMHC.
- Increase exposure among consumers, family members and providers.
- Address outreach, team building as well as training. Be sure the content addresses the values of MHSA and the Surgeon General's New Freedom Commission Report with regard to transformation of the mental health system.
- Create a statewide workforce to address all of these issues including a broader coalition, e.g. unions. This would include a statewide policy and funding for stipends.
- Fund outreach to ensure inclusion of underserved populations due to geographic location, racial, ethnic and language barriers.
- Training and outreach stipends and food, lodging and transportation should receive ongoing funding from MHSA funds. Honor values of each group and providers.
- Statewide hotline.

Other

- Telemedicine mini-grants and loans to start-up.
- Strategic framework to investigate alternative funding streams in order to maximize MHSA funding before MHSA funding is used or planned for use by counties: HUD, Mental Health Parity Enforcement/Reform, EPSDT.
- Telemedicine: for children; CEU training.
- Mental health courts should be part of community service plans.
- Respite services development that is available, accessible and comprehensive.
- Network of Care: state calendar should coordinate with local calendars. This is a tremendous network, which would provide "great bang for the buck." There may be potential media interest, as this may be a showcase program that community media would grab onto.